

PLEASE CLICK ON THE COUNTY OF LOS ANGELES SEAL
TO RETURN TO THIS PAGE

[CLICK HERE FOR THE DIRECTOR OF HEALTH SERVICE'S REPORT DATED SEPTEMBER 11, 2015](#)

[CLICK HERE FOR THE DIRECTOR OF HEALTH SERVICE'S REPORT DATED DECEMBER 11, 2015](#)

THIS ITEM RELATES TO ITEM #64-A ON BOARD MEETING HELD ON MAY 3, 2016
<http://file.lacounty.gov/bos/supdocs/104058.pdf>



September 11, 2015

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.



www.dhs.lacounty.gov

TO: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: MY HEALTH LA REDETERMINATION RATES

On August 11, 2015, the Board of Supervisors approved a motion instructing the Director of Health Services to report back within 30 days on the My Health LA (MHLA) program redetermination retention rates.

Summary

MHLA eligibility was set for a 12-month period with participants renewing their eligibility annually. The program's 12-month eligibility term and renewal provisions are designed to ensure that those MHLA participants renewing into the program continue to meet the County's eligibility requirements (e.g., that they still have household income at or below 138% of the Federal Poverty Level, are still uninsured and a still a resident of the County).

DHS defines retention as the percentage of enrolled MHLA participants scheduled to term (i.e., eligibility due to expire) in a given month who complete an annual renewal process before their term date. Because MHLA did not officially begin until October 2014, initial renewals are currently in progress making it difficult to assess renewal rates.

Preliminary analysis based solely on August 2014 pilot enrollment data indicates that 2,016 MHLA participants were eligible for renewal during August 2015. Of those 77% renewed and retained program participation while 23% were not renewed. DHS is doing additional analysis on the 23% that were not renewed. These non-renewals were most likely due to a combination of factors, such as, the person being no longer eligible, change in person's contact information/could not be reached, or person's intent to re-enroll at their next clinic visit. Those who are disenrolled from the program can re-enroll at any time with no penalty as long as they are still eligible. DHS believes that this renewal rate is favorable to other local communities with health access programs for the residually uninsured. With funding from the UniHealth Foundation, DHS is working collaboratively with the Community Clinic Association of Los Angeles County and MHLA Community Partner Clinics on enhance MHLA enrollment and retention processes to the fullest extent possible.

Although the annual redetermination period is written into the program's eligibility rules and programmed into the web-based eligibility determination and enrollment system, One-e-App, based on our experience with renewals over the course of the upcoming year and the UniHealth-sponsored partnership with our community partner clinics, DHS will bring proposals to the Board for how to do future renewals in year two and thereafter.

MHLA Preliminary Eligibility and Renewal

MHLA officially launched on October 1, 2014. MHLA uses a web-based eligibility and enrollment system, One-e-App, to determine program eligibility and is the system of record for MHLA enrollment.¹ To ensure timely renewals, MHLA participants receive mailed renewal notices 90, 60, and 30 days prior to the end of their annual term reminding them to do an in-person renewal. Renewal information is also included in all quarterly newsletters sent to MHLA participants. MHLA participants, including those who do not have addresses, are also contacted by their medical home (e.g., during a clinic visit, via telephone and/or via e-mail) to receive information about program renewal by their MHLA medical home. If the renewal is not done before the 12-month period expires, then the participant is disenrolled from the program. Individuals who are disenrolled from the program can re-enroll at any time with no program penalty as long as they meet the eligibility criteria.

Retention Rate

DHS defines retention as the percentage of enrolled MHLA participants scheduled to term (i.e., eligibility due to expire) in a given month who complete an annual renewal process before their term date. Note that a retention rate of 100% would not be expected since some MHLA participants will not be renewed because they may no longer meet MHLA eligibility criteria.

Because 12 months has not yet elapsed since the MHLA program began, it is too early to begin calculating program redetermination rates since the first program renewals are currently in progress. The only MHLA participants for whom DHS has preliminary renewal rates are those individuals who enrolled in August 2014 as part of the MHLA One-e-App pilot.

Of the 2,016 MHLA participants who constitute the number of MHLA individuals due to renew their eligibility in August 2015:

- 1,549 (77%) were renewed and
- 467 (23%) were not renewed.

As stated above, DHS is doing additional analysis on the 23% that were not renewed.

MHLA Renewal Committee

While MHLA participants can re-enroll at any time due to the voluntary nature of the program and lack of penalty associated with disenrollment, DHS believes that continuous enrollment (for those who have their eligibility re-determined) can be beneficial because it:

- 1) promotes continuity of care and streamlined access to subsidized services,
- 2) helps MHLA participants become accustomed to program participation and
- 3) contributes to stable program administration, budget, enrollment and operations.

In July 2015, DHS and the Community Clinic Association of Los Angeles County (CCALAC) officially launched a UniHealth Foundation funded joint effort to establish a MHLA enrollment and retention best practices initiative for One-e-App users. This 12-month, \$300,000 grant is to foster opportunities for DHS and CCALAC to build a strong renewal structure including the creation and implementation of a renewal campaign to support MHLA retention, enhance existing enrollment training and education

¹ Before launching One-e-App at all participating MHLA clinic sites, it was piloted by nine (9) MHLA community clinic agencies beginning August 4, 2014. The purpose of the pilot was to allow a limited number of Community Partner (CP) authorized users to use the One-e-App in a production environment and report their enrollment experiences to help DHS refine the system prior to roll-out for the non-pilot MHLA clinic agencies and sites.

infrastructure and revise, create, and/or retire resources and materials for community partners and One-e-App users related to enrollment and renewals.²

The MHLA Renewal Committee is made up of representatives from the DHS, CCALAC and a MHLA Eligibility Leads and One-e-App Leads from MHLA Community Partners. The Committee currently meets twice per month and has the following goals:

- Recommend and monitor MHLA target renewal rates, to include standard and renewal rates adjusted for preventable versus unpreventable renewal terminations.
- Recommend and share proposed strategies and tactics to remove renewal barriers for MHLA participants and Community Partner Clinics.
- Recommend and share best practices to improve the accuracy and completeness of MHLA applications.
- Identify training and education opportunities to improve MHLA Enroller performance across all clinics.
- Identify opportunities to screen renewing participants for other coverage programs, such as Medi-Cal under Deferred Action for Childhood Arrivals (DACA).

Thus far, the Committee has accomplished the following:

- Conducted a detailed clinic survey to acquire information about the MHLA enroller workforce that can be used to inform enhancement of the program's training and education infrastructure.
- Outlined learning gaps with MHLA enrollers and training opportunities for the MHLA program for new and existing enrollment staff
- Conducted an all-clinic "Renewals Best Practices" webinar with DHS, CCALAC and One-e-App and Eligibility Leads for all MHLA clinics. This webinar created a learning and sharing session on MHLA renewal best practices and created a forum for clinics to share with each other techniques and tools that can be adopted by all MHLA Community Partners to maximize our collective MHLA renewal efforts.

DHS is scheduled to present the fiscal year 2014-15 annual report on MHLA at the Health and Mental Health Cluster Meeting in November 2015 which will include updated information on renewal rates.

If you have any questions, please do not hesitate to contact me at 213.240.8101.

MHK:TB

cc: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

² The Board approved the grant on May 19, 2015 which allocates \$200,000 for DHS and \$100,000 for CCALAC.



Health Services
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Deputy Director, Strategy and Operations

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.



www.dhs.lacounty.gov

December 11, 2015

TO: Chair Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: MY HEALTH LA PROGRAM

On August 11, 2015 the LA County Board of Supervisors approved a motion instructing the Director of Health Services, in consultation with the Interim Director of Public Health and the Community Clinic Association of Los Angeles County (CCALAC), to report back to the Board in 120 days on options to improve the My Health Los Angeles program, including those listed below

- increasing the eligibility income threshold (to 150% FPL or higher);
- expanding the dental benefits;
- adding substance abuse benefits;
- allocating funding for integrated medical services at sites providing mental health and substance abuse services; and
- relaxing redetermination requirements so that they are no more stringent and burdensome than federal Medicaid requirements, but program fiscal integrity is maintained.

In addition, on September 29, 2015, the Board of Supervisors approved a motion instructing the Director of Health Services:

- to report back on options to ensure that the County maximizes enrollment in the My Health L.A. Program (taking into account that enrollment will fluctuate due to such factors as natural program disenrollment/attrition as a result of participant ineligibility) and that all program funds are expended in Fiscal Year 2015-16 and
- to examine the feasibility of enhancing culturally competent and linguistically appropriate outreach efforts with the community-based organizations (CBOs) who work with individuals and families who are eligible for My Health LA, as well as, creating a process for a "warm hand-off" between the CBOs to My Health LA providers to bridge the opportunities for enrollment.

Background

On October 1, 2014, DHS formally launched the My Health LA (MHLA) program, to provide primary health care services to low income, uninsured residents of Los Angeles County. The program is currently operating at 54 clinic agencies at over 190 clinic sites. Enrollment in MHLA is voluntary. As of October 31, 2015, almost 138,000 individuals were enrolled in the program (94.5% of targeted

146,000 enrollees). This makes it the largest program for the residually uninsured in the United States.

Recently approved program amendments by your Board will facilitate enrollment of hard to reach populations and is likely to increase the size of the program. Specifically, on November 17, 2015, the Board approved amendments to the MHLA agreement that:

- expands the number of sites where MHLA applications can be taken by adding administrative enrollment sites and modifying the definition of medical home to include satellite clinic locations and mobile clinics,
- allows one MHLA participant in a household to renew on behalf of everyone in the household as long as the person maintains program eligibility,
- removes the dental care provider maximum dental allocation (while maintaining the overall MHLA program allocation set by the Board).

These amendments expanded enrollment and access to MHLA services (i.e., dental) in ways that are responsive to the requests of these two motions. The amendments will help ensure that the \$61 million allocated in fiscal year 2015-16 is expended to the fullest extent possible.

Consistent with the Board's request, DHS met and consulted with CCALAC on the Board motions. CCALAC and its members prepared a document with its suggested recommendations in response to the motion. DHS has included this document as an attachment to this Board response (see Attachment A) and addresses some of the CCALAC and community clinic recommendations in this response.¹ Overall, we agree with the importance of increasing access and streamlining processes. MHLA has only been in existence for one year and is dramatically different from its predecessor programs. It is not surprising that we are identifying ways to make the program better.

Increasing the Eligibility Income Threshold (To 150% or Higher)

The MHLA income eligibility threshold is 138% of the Federal Poverty Level (FPL). This income eligibility standard was established so that it matched the State's eligibility standard for full-scope no share of cost Medi-Cal. In addition, DHS' Ability To Pay program provides health care services at no cost for those with incomes at or below 138% FPL if they do not qualify for Medi-Cal or Medicare.

The ability to increase the eligibility income threshold requires:

- understanding current enrollment and potential enrollment trends,
- determining how many individuals may be uninsured above 138% FPL,
- examining the financial implications of any increase in income eligibility,
- assessing whether MHLA community clinics/medical homes have the capacity to serve additional enrollees and
- ensuring that MHLA does not create an unintended consequence discouraging enrollment in publicly-supported health insurance.

The MHLA fiscal year 2015-16 program budget is based on a targeted monthly enrollment of 146,000. As noted above, there are approximately 138,000 MHLA participants (94.5% of its target enrollment).

¹ CCALAC's document requests a DHS review of certain MHLA program requirements. DHS will contact CCALAC to schedule a discussion on those areas of concern that will include MHLA leadership, eligibility and enrollment staff, and the quality management/audit units.

This means that there is sufficient funding for another 8,000 participants. The program's enrollment continues to increase each month (although the rate of increase has slowed due to program maturity and natural enrollment fluctuations that arise from annual program renewal activity). MHLA enrollment may reach 146,000 without an increase in the income threshold.

Given that the 146,000 enrollment target was based on the number of patients served by community clinics that participated in the former Healthy Way LA Unmatched, Community Clinic Expansion Program and SB 474 programs, DHS worked with CCALAC to determine if MHLA community clinics could provide data on the number of uninsured clients with incomes above 138% FPL. However, community clinics were unable to estimate this. One of the challenges is that clinic databases and reports do not have an income cut-off criteria at 138% FPL (i.e., most clinics have their data systems programmed to report income in the following ranges: below 100% FPL, 100% – 150% FPL, 150% - 200% FPL, etc.).

As an alternative to community clinic data, DHS obtained estimated data from the 2014 California Health Interview Survey (CHIS) which is conducted by the Center for Health Policy Studies at the University of California at Los Angeles. Specifically, DHS queried:

- calendar year 2014 (most recent year available),
- Los Angeles County,
- current coverage (insured or not insured),
- citizenship status (U.S. both citizen, naturalized citizen or non-citizen),
- all ages and
- income (139% to 164% FPL; CHIS requires that there be at least a 25 point difference in the income range field to help ensure statistical stability).

The data query revealed that there are an estimated 77,000 uninsured residents (all ages) in the County with incomes between 139% FPL and 164% FPL. Of those, 22,000 are estimated to be non-citizens and therefore potentially eligible. If an even distribution of the 22,000 uninsured individuals is assumed across the 25-point income range, then every one percentage point increase in income is associated with 880 uninsured individuals ($22,000 \div 25$). Therefore, it is estimated that there are under 10,000 uninsured residents between 139% FPL and 150% FPL ($880 \times 11 = 9,680$) who would meet this income threshold.

Currently, MHLA community clinics receive a \$32 Monthly Grant Fund amount (\$28 for medical and \$4 for pharmacy) for each enrolled participant (or annual reimbursement of \$384 assuming 12 months of enrollment). DHS recognizes that: (1) because MHLA is a voluntary program, not all 9,860 residents will enroll, (2) any enrollment would occur over time and not all at once and (3) some uninsured resident may use non MHLA service providers to obtain free or discounted health care and therefore be uninterested in participating in the program. The table below provides information on the estimated cost of potentially increasing the income eligibility threshold to 150% FPL at different penetration rates (recognizing that 100% enrollment is highly unlikely).

<i>Percent of 9,680 Population</i>	<i>Number of Enrollees</i>	<i>Current Annual Cost (12 months)</i>	<i>Estimated Cost Increase</i>
25%	2,420	\$384	\$929,280
50%	4,840	\$384	\$1,858,560
75%	7,260	\$384	\$2,787,840
100%	9,680	\$384	\$3,717,120

Note that if the income threshold were increased, DHS would have to work with CCALAC and the community clinics to determine if there was sufficient capacity to provide health care services to the additional program participants.

There are also an estimated 240,000 residents who remain uninsured despite eligibility for health insurance through Covered California (the State's health benefits exchange). Although all efforts would be made to encourage those who are eligible to apply for health insurance through Covered California, it is inevitable that some persons eligible for the exchange would apply for MHLA. To avoid this, DHS may need to explore establishing a participant cost structure for those individuals with income above 138% FPL to ensure that:

- there is some level of parity with individuals who are at the same income level and are required to pay some portion of the cost of their healthcare when receiving publicly-financed health care (e.g., DHS' Ability to Pay program has low-cost fees for uninsured individuals with income over 138% FPL and the State's Covered California program requires premiums [subsidized] and co-payments for those with incomes over 138% FPL) and
- the income eligibility increase does not create a disincentive for eligible individuals to enroll in other publicly funded health insurance with member share of cost fees (e.g., DHS' Ability to Pay, Covered California, Medicare).

At this time, DHS recommends revisiting the option of increasing the MHLA income eligibility threshold after there has been sufficient time to gauge the impact of recent MHLA programmatic changes designed to expand enrollment. This recommendation is consistent with that of CCALAC. DHS notes that enrollment beyond 146,000 would require additional funding.

Expanding Dental Benefits

DHS is supportive of expanding access to dental services funded under the MHLA program. To this end, DHS, in partnership with the community clinics, recently took important steps to increase access to dental services. This includes:

- In July 2015, at the request of the community clinics, DHS expanded the number of dental codes (i.e., dental services provided) that can be billed under the MHLA program. DHS added twenty-three (23) new dental codes/services that were identified as being most needed by uninsured patients, but which were not previously covered.
- The Board's November 17, 2015 approval of amendments to the MHLA Agreement removed the maximum dental allocation for community clinics with dental contracts. This simplifies the process for clinics to obtain dental funding and eliminates maximum dental allocations by clinics, such that dental funding caps will no longer be a barrier for a MHLA dental clinic that wishes to increase the level or expand the type of dental services provided to MHLA enrolled or eligible patients.

Currently, the MHLA program pays Denti-Cal rates for all covered dental services provided under the MHLA program. DHS understands why CCALAC and community clinics recommend "a dental services cost study that could inform a data-driven payment methodology for the dental program, with the goal of evaluating the true cost of services provided to MHLA enrollees." Denti-Cal rates are too low. However, DHS is very uncomfortable with recommending the use of scarce County General Fund dollars to pay for dental service rates that are higher than what the State pays for the same service.

Adding Substance Abuse Benefits

Substance abuse treatment services are not covered by the My Health LA program (MHLA). DHS recognizes that substance use disorders (SUD) may affect health status. Currently, MHLA participants can self-refer or be referred by their MHLA medical home doctor to the LA County Department of Public Health's (DPH) Substance Abuse Prevention and Control (SAPC) hotline for services. This hotline is open Monday through Friday from 8 am to 5 pm. The hotline's toll-free number is on the back of the MHLA identification card.

DPH's Substance Abuse Prevention and Control Division, in consultation with DHS, has determined that it is possible to expand the MHLA scope of benefits to include SUD services for adolescents and adults. Substance abuse services will be available July 1, 2016.

The following is the list of SUD services that MHLA participants will have access to. The scope of services is based on the SUD benefit packages offered by DPH.

LEVEL OF CARE	ADULT SUD BENEFIT PACKAGE	ADOLESCENT SUD BENEFIT PACKAGE
Early Intervention*	Yes	Yes
Outpatient	Yes	Yes
Intensive Outpatient	Yes	Yes
Low Intensity Residential	Yes	Yes
High Intensity Residential (Population Specific)	Yes	No
High Intensity Residential (Non-Population Specific)	Yes	Yes
Intensive Inpatient Services - Medically Monitored*	Yes	Yes
Intensive Inpatient Services - Medically Managed*	Yes	Yes
Ambulatory Withdrawal Management (Without Extended On-Site Monitoring)	Yes	Yes
Ambulatory Withdrawal Management (With Extended On-Site Monitoring)	Yes	No**
Residential Withdrawal Management - Clinically Managed	Yes	No**
Inpatient Withdrawal Management - Clinically Managed*	Yes	No**
Inpatient Withdrawal Management - Medically Managed and Intensive Services*	Yes	No**
Opioid (Narcotic) Treatment Program	Yes	No
Additional Medication Assisted Treatment	Yes	No
Case Management	Yes	Yes
Recovery Services (Post Treatment)	Yes	Yes
Physician Consultation	Yes	Yes

* Levels of care and SUD services that are not provided within the SAPC network of providers, but are available via other systems of care (e.g., DHS) and providers within Los Angeles County.

** Levels of care that are offered on a case-by-case basis dependent on clinical need, given the varying SUD needs of the adolescent population.

DPH's Substance Abuse Prevention and Control Division and its contracted service providers will be responsible for determining the appropriate level of SUD care needed for any referred MHLA

participant based on an assessment and clinical standards. Note that SUD services for adolescents will only be provided until implementation of Senate Bill 75 which expands full-scope Medi-Cal to all Californians aged 0 – 18, including undocumented children. When SB 75 is implemented, MHLA participants aged 0 – 18 will be transitioned into Medi-Cal and the Adolescent SUD Benefits Package will no longer be needed or available under the program.

DPH has indicated that it will be able to use State Realignment funds to provide SUD services to MHLA participants and that current estimates indicate that no additional Net County Costs will be needed.

In order to provide SUD services to MHLA participants, DHS and DPH will work on the following:

- amending contracts with DPH SUD providers to include MHLA as a service population,
- educating SUD providers about MHLA, its unique patient population, and working with them to record MHLA participant identifying information on service claims for data utilization and tracking purposes,
- educating MHLA medical homes on the availability of SUD services,
- educating MHLA participants on the availability of SUD services and
- updating MHLA program materials to include SUD as a covered service.

This is consistent with the recommendation of CCALAC and DHS looks forward to working with them and DPH's SAPC to implement this new benefit.

Funding for Integrated Medical Services

DHS supports the notion of integrated medical services at sites providing mental health and substance abuse services. As the Board is aware, integration is a driving force behind efforts to improve access to a comprehensive delivery system for individuals who are users of health, mental health and substance abuse services. DHS concurs with CCALAC that the issues of how best to locate/co-locate services are complex and that further study is needed. At this moment, the integration efforts under the Health Agency are in their infancy. DHS requests additional time to work with the Board, the other Departments and the Health Agency's Integrated Advisory Board before making concrete proposals in this area.

Relaxing Redetermination Requirements While Maintaining Program Fiscal Integrity

MHLA eligibility is for a 12-month period with participants renewing their eligibility annually. The program's 12-month eligibility term and renewal provisions are designed to ensure that those MHLA participants renewing into the program continue to meet the County's eligibility requirements (e.g., that they still have household income eligibility, are still uninsured and are still a resident of the County).

DHS is committed to working with community partner clinics to maintain high levels of participant renewals in the program. To date, the MHLA program has worked closely with the clinics and CCALAC to develop and implement strategies to achieve this. For example, DHS, in collaboration with community clinics and CCALAC, have implemented several important strategies to increase renewal rates and streamline the renewal process, including:

- Developed a MHLA Renewal Committee made up of DHS, CCALAC and community clinics representatives. The Committee is tasked with developing and monitoring target renewal rates (adjusted for preventable versus unpreventable renewal terminations), recommending

strategies and tactics to remove renewal barriers for MHLA participants and Community Partner (CP) enrollers, recommending best practices to improve the accuracy and completeness of MHLA applications and identifying training and education opportunities to improve clinic renewal rates and MHLA enroller performance. Some of the recommendations outlined in this report had their genesis with the Committee and participating community clinics.

- The MHLA Agreement was amended on November 17, 2015, to relax the renewal process for MHLA participants by allowing one member of a household to renew on behalf of everyone in the household. This means that one adult can bring in the renewal documentation on behalf of every other member of the family.
- The renewal process was shortened by eliminating the requirement that renewing participants re-sign the MHLA Rights and Declaration page and removing the requirement that clinic enrollers re-upload this document.
- The MHLA Eligibility and Enrollment Unit (ERU) created eligibility "Subject Matter Experts" who provide ongoing assistance to clinic enrollers in real-time on enrollment and renewal questions and issues.

Because of these changes, MHLA mirrors the Medi-Cal's renewal/redetermination in the following ways:

1. One adult in the household can re-enroll on behalf of the family.
2. MHLA eligibility is maintained for the entire month, such that even if a person is disenrolled for failure to renew (or any other reason) anytime during the month, their MHLA coverage is maintained until the end of the month (unless requested otherwise by another Federal, State, or County program). This means that if a disenrolled person re-enrolls in the same month of their disenrollment, there is no break in coverage.
3. MHLA allows an adult's verification information to be used to satisfy a minor's verification requirements (e.g. identify and address verification) for those in the same household.

One aspect of Medi-Cal redetermination that DHS is not able to mirror in MHLA is automated income eligibility. Under federal law, State Medicaid programs can access other State and federal databases to facilitate and streamline the redetermination. This is done through an automated process and data sharing agreements that states have with the federal government. In California, it negates the need for Medi-Cal beneficiaries to submit written documentation on their income during the renewal process. Unfortunately, federal law does not extend this privilege to localities with health care access programs such as MHLA. This means that the MHLA program and the web-based eligibility and enrollment system One-e-App cannot automatically verify a renewing participant's income or other eligibility absent the participant providing the information themselves.

That being said, the MHLA program continues to examine new strategies to simplify the renewal process. Currently, DHS is working with clinics to explore new ways to streamline the renewal process within the eligibility and enrollment system One-e-App in those instances where there has been no change in household status and eligibility. DHS is in the process of exploring, with the One-e-App vendor, whether it is technically feasible to make possible programming changes/reconfigurations to the system to further facilitate program renewal.

DHS defines retention as the percentage of enrolled MHLA participants scheduled to term (i.e., eligibility due to expire) in a given month who complete an annual renewal process before their term date. As DHS noted in a September 11, 2015 report to the Board, MHLA participants can re-enroll at any time due to the voluntary nature of the program and lack of penalty associated with disenrollment and re-enrollment. The renewal rates for the program thus far are as follows:

- 80% of those due for renewal in August 2015 attempted to renew eligibility – of those 73% were approved for continued program participation and 7% were denied
- 73% of those due for renewal in September 2015 attempted to renew eligibility – of those 71% were approved for continued program participation and 2% were denied
- 66% of those due for renewal in October 2015 attempted to renew eligibility – of those 65% were approved for continued program participation and 1% were denied

MHLA participants renewing eligibility will be denied because they no longer meet the program's criteria (i.e., income in excess on eligibility threshold, are insured, or no longer reside in the County).

It should be noted that October 2015 was the first month that all agencies in the MHLA network conducted renewals, most for the first time. It also had the largest cohort of participants eligible for renewal with October 2014 being the month with the highest number of new enrollments. Therefore, the decrease in the renewal rate may be due to these factors or others. DHS will continually monitor renewals to determine if any patterns arise since we share the Board's, CCALAC's and community clinic's interest in ensuring that all MHLA participants interested in renewing without a break in enrollment and coverage are able to do so.

CCALAC noted that some clinic staff are struggling to understand how to generate renewal reports in the One-e-App system. DHS has already begun working with the One-e-App vendor to reconfigure these reports, which requires programming changes. In addition, MHLA staff provided a detailed training to clinics on April 29, 2015, April 30, 2015, June 25, 2015 and June 26, 2015 on how to conduct renewals in One-e-App and to generate renewal reports. DHS will hold additional trainings once the aforementioned changes to the renewal reports are in production. CCALAC recommends increased communication and messaging tools around the MHLA program and renewals and DHS will continue to work with CCALAC in this area. Currently, the MHLA Renewal Committee is working on the development of a renewal "toolkit" which will include: resources on how to pull reports that support the renewal process, sample renewal call scripts, sample appointment reminder cards, sample renewal flyers, renewal key messages, and the OEA renewal fact sheets and presentations. In addition, the MHLA program continues to promote a "culture of coverage" with MHLA participants. Most recently, MHLA placed an article about the importance of keeping and renewing MHLA coverage on the first page of the MHLA participant newsletter, called "My Healthy News," which was sent to program participants in October 2015 and is being inserted in all new enrollee packets.

CCALAC also recommends that DHS allow community clinics to conduct MHLA enrollments and renewals in the community outside of the MHLA medical home. As reported to the Board in May 2015, DHS is supportive of doing outreach to potential MHLA applicants and has worked with CCALAC to make this happen. DHS developed and implemented a standardized MHLA contract waiver process and form that allows community clinics to conduct MHLA enrollment activities at community-based events. DHS has approved each and every MHLA medical home request for a community-based MHLA enrollment event using this process and form. In addition, as previously described, the Board's November 17, 2015 approval of amendments to the MHLA Agreement allows MHLA enrollments at administrative enrollment sites, new satellite sites and mobile vans (so long as

the vans keep to a consistent schedule). These important changes to the MHLA agreement should allow for more flexible community-based enrollments (and renewals) outside of the clinic setting.

Maximize My Health LA Program Enrollment

DHS supports efforts to maximize MHLA enrollment tied to the 146,000 targeted enrollment budgeted for the program. As noted above, there are almost 138,000 uninsured Los Angeles residents participating in MHLA (94.5% of the target population).

The amendments to the MHLA program agreement approved by the Board on November 17, 2015 further maximized enrollment by:

- expanding the definition of medical homes which in turn increases the number sites that can enroll MHLA applicants by an additional 21 new locations
- revising the definition of satellite site allowing 17 locations to participate as medical homes and enroll applicants into the MHLA program
- creating a newly defined Administrative Enrollment Site category where MHLA program enrollment can occur
- simplifying the renewal process to allow one adult MHLA participant in a household to renew on behalf of everyone in that household.

These changes are in addition to the process community clinics use to conduct MHLA enrollment activities at community-based events as noted above.

DHS believes that these various program changes will help maximize enrollment, taking into account that enrollment will fluctuate due to such factors as natural program disenrollment/attrition. These changes coupled with modifications to dental services and implementation of the MHLA Pharmacy Phase II component will contribute to more fully spending the Fiscal Year 2015-16 allocation of \$61 million. Given this, DHS recommends that at this time, it closely monitor the impact of these changes on enrollment and expenditures before proposing any additional changes.

Enhancing Culturally Competent and Linguistically Appropriate Outreach Efforts

In October 2015, DHS began a partnership with CCALAC and Community Based Organizations (CBOs) through a grant funded by the Blue Shield of California Foundation to work with CBOs to maintain and expand MHLA enrollment. The deliverables of this grant include: (1) preparing for the transition of the 0-18 children from MHLA into Medi-Cal, (2) increasing the number of patients participating in the MHLA dental program, and (3) maintaining high enrollment in the MHLA program, involving both community clinics and CBOs in the development of strategies to meet these goals.

Currently, largely due to the very high level of confidential and sensitive Public Health Information (PHI) available to any user of the One-e-App system, only trained/certified enrollers employed by contracted MHLA clinics may access the One-e-App system to do enrollment. However, DHS is supportive of clinics working with CBOs to do outreach and enrollment, and the program has created a process, previously described, for clinics to partner with CBOs to do community-based outreach and enrollment at health fairs and events. In addition, to help support these outreach events, DHS translated outreach materials into several new languages including Armenian, Chinese, Korean, Tagalog and Thai (in addition to the existing Spanish and English languages).

The MHLA program revised the standardized MHLA contract waiver form used by community clinics to request community-based enrollment to make it shorter and faster for clinics to complete. In addition, it is possible that some clinic enrollers may not be aware that they are permitted to partner with CBOs to do community-based enrollment and so DHS has begun an outreach campaign to clinics through email, conference calls and the MHLA Community Partner Connection Newsletter to make sure all clinics are aware that these kinds of community-based outreach events are currently permitted.

DHS is also supportive of helping clinics create a warm "hand-off" process for patients identified as potentially eligible for MHLA by CBOs in order to bridge opportunities for enrollment. MHLA staff currently participate in monthly LA Health Access meetings which are attended by numerous health and advocacy groups, and through this forum MHLA staff have been working with the advocacy community to develop new, customizable outreach materials for potential enrollees that can be used to help applicants understand the health benefits (including dental care) of enrolling in the MHLA program, encourage them to not be afraid to enroll, and help them learn how to find a nearby clinic. This new outreach toolkit will be translated into multiple languages.

DHS is proud of the success of the MHLA and looks forward to working with the Board and our community partners to expand the enrollment and benefits.

If you have any questions, please do not hesitate to contact me at 213.240.8101.

MHK:tmb

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

ATTACHMENT A



Member Driven. Patient Focused.

Recommendations for the August 11, 2015 LA County Board of Supervisors' Motion on My Health LA

On August 11, 2015 the LA County Board of Supervisors approved the following motion:

Instruct the Director of Health Services, in consultation with the Interim Director of Public Health and the Los Angeles County Community Clinic Association, to report back to the Board in writing in 120 days (unless corrective actions are needed sooner) on options to improve the My Health Los Angeles Program, including those listed below; and instruct the Director of Health Services to report back to the Board in 30 days on current redetermination retention rates:

- *Increasing the eligibility income threshold (to 150% or higher);*
- *Expanding the dental benefits;*
- *Adding substance abuse benefits;*
- *Allocating funding for integrated medical services at sites providing mental health and substance abuse services; and*
- *Relaxing redetermination requirements so that they are no more stringent and burdensome than federal Medicaid requirements, but program fiscal integrity is maintained.*

The Community Clinic Association of LA County (CCALAC) appreciates our continued partnership with the Board of Supervisors and the County Departments as we work closely to identify improvements to the MHLA program. To respond to the August motion, CCALAC convened three workgroups to provide recommendations to the Director of LA County Department of Health Services (LADHS) to inform his report to the Board. On November 9, 2015, CCALAC's membership approved the following recommendations for each of the components of the My Health LA (MHLA) motion.

OVERARCHING RECOMMENDATION: ADMINISTRATIVE SIMPLIFICATION

Beyond the individual components of the MHLA Program called out in the Board's motion, Community Partners urge the Board and LADHS to support initiatives that increased administrative simplification at both the patient and contractor levels in the MHLA program. Community Partners currently wade through layers of requirements and duplicative processes for provider and beneficiary enrollment, billing and auditing. CCALAC recommends a review of certain program requirements, particularly in those areas where requirements are more stringent than those set forth by the state and federal governments.

INCREASING THE ELIGIBILITY INCOME THRESHOLD (TO 150% OR HIGHER)

Community Partners support raising the MHLA income eligibility threshold, so that more eligible patients are able to enroll in MHLA. In order to do this effectively, we recommend that LADHS:

- Assess the impact of the expansion, per the 2015-16 contract amendment, of enrollment sites and renewals on total program enrollment before pursuing significant enrollment-related changes to the MHLA program, in light of the current 146,000 program capacity.
- Provide training to mitigate administrative complexity for MHLA enrollment staff as they manage multiple programs with varying eligibility criteria and rules.
- Work proactively to mitigate communication and patient education challenges within communities with respect to raising the eligibility threshold, particularly with the varying eligibility criteria between MHLA, Medi-Cal and Covered CA.

EXPANDING THE DENTAL BENEFITS

Community Partners support expansion of the dental benefits provided under MHLA and a strengthening of the MHLA dental program, overall. In order to do this effectively, we recommend that LADHS:

- Recognize the importance of dental services as part of primary care, and pay a fair, adequate reimbursement that would secure increased dental access broadly in the MHLA program.
- Conduct a dental services cost study that could inform a data-driven payment methodology for the dental program, with the goal of evaluating the true cost of services provided to MHLA enrollees.

ADDING SUBSTANCE ABUSE BENEFITS

Community Partners support the addition of resources to include substance abuse benefits in the MHLA program. We commit to working with LADHS and the LADPH Substance Abuse and Prevention Control (SAPC) over the course of the next year to design the best program possible. This should be done in concert with the Drug Medi-Cal (DMC) Waiver Implementation Plan.

ALLOCATING FUNDING FOR INTEGRATED MEDICAL SERVICES AT SITES PROVIDING MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Before allocating funding to provide medical services at LADMH and SAPC-contracted sites, we recommend that LADHS:

- Assess demand for MHLA services at existing LA County Department of Mental Health (LADMH) sites. Co-location of primary care at a LADMH site may not always be appropriate depending on patient demand, available space, etc.
- Encourage alternative strategies for providing collocated and integrated care to MHLA patients, such as contracting with FQHCs to provide mental health services on site for patients and partnering with other LADMH contractors in the community, must be considered.
- Further explore graphical representation of these different options.

RELAXING REDETERMINATION REQUIREMENTS SO THAT THEY ARE NO MORE STRINGENT AND BURDENSOME THAN FEDERAL MEDICAID REQUIREMENTS, BUT PROGRAM FISCAL INTEGRITY IS MAINTAINED

Community Partners support administrative simplification broadly in MHLA, and especially in the areas of enrollment and redetermination. To simplify the process for our patients, we recommend that LADHS:

- Allow for CPs to conduct off-site community-based enrollment and renewals, to maximize program capacity and retention.
- Invest in fixes to the One-e-App (OEA) system to facilitate enrollment and renewals. For example:
 - CP staff processing renewal applications must currently go screen-by-screen through the entire application – making the renewal process as onerous as enrollment, when it should be simpler.
 - CP staff struggle significantly with the renewal reports generated by OEA and have suggested a number of changes to make them understandable and useable. LADHS should prioritize these fixes, and then provide detailed training to all CPs around generating, formatting, understanding and using the OEA reports.
- Increase MHLA Program's patient messaging and communication around the program and specifically around renewals, to foster a sense of "belonging" to the MHLA program and create a "culture of coverage" among MHLA patients.
- Invest resources to support MHLA enrollment and renewal work being done by CP staff. CPs, if they have the resources, spend significant amounts of time and energy conducting renewals outreach. Those without as many resources cannot do the appropriate outreach, even though patient engagement is effective at getting patients in to renew.